STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. BUILDING _____ B. WING _____	C 12/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE NURSING & REHABILITATION CENTER	505 GREENBANK ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from December 14, 2011 and ended on December 21, 2011. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility records and hospital documentation as indicated. The facility census the first day of the survey was 160. The survey sample totaled seven (7) residents which included 6 closed records and one (1) active record. Additionally, there was one (1) subsampled resident.	F 000	**Disclaimer Statement:** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of both Federal and State Laws.	
F 162 SS=B	483.10(c)(8) LIMITATION ON CHARGES TO PERSONAL FUNDS The facility may not impose a charge against the personal funds of a resident for any item or services for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.) During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services: Nursing services as required at §483.30 of this	F 162	483.10(c)(8) LIMITATION ON CHARGES TO PERSONAL FUNDS 1. Resident R4 was not under a Medicare/Medicaid covered stay. She was a private pay resident who was receiving Delaware Hospice Services. The facility will contact the hospice to determine the drugs which should have been covered by the hospice pharmacy. The verified drugs will be billed to the hospice pharmacy and a refund will be issued to the resident. 2. Residents covered under a Medicare/Medicaid stay could be affected.	1/30/12 1/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Fred Gibbons | Administrator | 1/20/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 162	Continued From page 1 subpart. Dietary services as required at §483.35 of this subpart. An activities program as required at §483.15(f) of this subpart. Room/bed maintenance services. Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry. Medically-related social services as required at §483.15(g) of this subpart. Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: Telephone. Television/radio for personal use. Personal comfort items, including smoking materials, notions and novelties, and confections. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. Personal clothing. Personal reading matter.	F 162	483.10(c)(8) LIMITATION ON CHARGES TO PERSONAL FUNDS (con't) 3. The facility will review billing procedures with each Hospice to verify billing practice and service . 4. Hospice/respite related medications billing will be monitored and reviewed by business office manager/designee monthly X 3 and reported through QA process.	1/30/12 1/30/12

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F 162	Continued From page 2 Gifts purchased on behalf of a resident. Flowers and plants. Social events and entertainment offered outside the scope of the activities program, provided under §483.15(f) of this subpart. Noncovered special care services such as privately hired nurses or aides. Private room, except when therapeutically required (for example, isolation for infection control). Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by §483.35 of this subpart. The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident. The facility must not require a resident (or his or her representative) to request any item or services as a condition of admission or continued stay. The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be. This REQUIREMENT is not met as evidenced by: Based on record review, facility and hospice staff interviews, it was determined that the facility failed to ensure that one resident (R4) was not imposed a charge against personal funds for multiple doses of a medication (Seroquel for agitation), for which payment was covered by the hospice organization. Facility charged R4 for multiple doses of Seroquel which was covered under the Hospice benefit. Findings include:	F 162	See Previous Page	

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F 162	Continued From page 3 R4 was admitted to the facility on 2/17/11 from the hospital as a respite patient of a hospice organization. Diagnoses for R4 included senile dementia, high cholesterol and hypertension. R4's record indicated that R4 was discharged to an assisted living facility on 2/25/11. The total stay at the facility was eight days. Record review of Hospice documentation for R4 revealed that Seroquel was a medication that was part of the resident Hospice Care Plan and a covered medication under the hospice plan. On 12/19/11 review of the facility billing documents for medication charges for R4 with E5 (Finance Office staff) revealed, that on 3/20/11 R4 was charged/paid for a total bill $708.48 which included multiple doses of Seroquel 50 mg bill of $158.08. An additional Seroquel pharmacy bill dated 2/20/11 was paid by R4's family member for $81.50. The medication bill was paid by R4's responsible party out-of-pocket on 7/6/11 for all medications indicated by the physician during R4's stay at the facility. Payment for multiple doses of Seroquel was part of the hospice plan of care and hospice was responsible for payment. Review of the Hospice Care Plan (POC) indicated that Seroquel was related to the hospice diagnosis for R4's care. In an interview with E6 (Hospice Staff) on 12/19/11, she revealed that the plan of care indicated the medications that were required for R4 to have and confirmed that Seroquel should not have been charged against the resident's funds as their organization should have paid for this medication. E6 stated that she would contact the hospice social worker to connect with the family about this charge and that	F 162	See Previous Page	

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F 162	Continued From page 4 they will work on correcting this. In an interview with E5 (Finance Office) and E7 (Admissions director) on 12/21/11, they confirmed that they were not aware Seroquel should not have been charged to the resident and that the medication was covered under Hospice. E5 stated that she paid the bills or requested payment when she received the information from the pharmacy. E7 stated that she received the plan of care upon admission from hospice for residents, and was not here when the resident was charged for the medications. She stated she was not aware that medications on the Hospice POC listed covered and non-covered medications. E5 and E7 referred the surveyor to talk to the DON. In an interview with E2 (DON) on 12/21/11 he revealed that when a resident comes in to the facility, they follow the facility standard protocol. They review the medications provided by the hospital against those provided by the physicians and then place the orders for the medications. E2 stated that they review the hospice POC but he did not provide information on the Hospice POC listing required medications to billing."The billing is not part of nursing ". Facility charged R4 a total of $239.58 for multiple doses of Seroquel medication which was covered under Hospice care and should have been charged to Hospice. Facility failed to identify what medications should have been charged to Hospice and not to the resident. The facility imposed a charge against R4's funds for a medication that should have been covered	F 162	See Previous Page	

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F 162	Continued From page 5 by the Hospice organization.	F 162		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	483.13(c)(1)(ii)-(iii), (c)(2)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 1. R7 received an abrasion to Right Great Toe that resolved without complication. No abuse or neglect was suspected and an abrasion is not a reportable incident under Delaware code. However, an internal incident report was completed during the survey and investigation determined no abuse, neglect, or mistreatment could be substantiated. 2. Any injury from an incident of unknown source in which the initial investigation or evaluation supports the conclusion that the injury is suspicious. Circumstances which may cause an injury to be suspicious are: the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries at one particular point in time, or the incidence of injuries over time.	12/16/11 1/30/12

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F 225	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review and review of facility policies and procedures and other documentation, it was determined that the facility failed to ensure that one (1) resident (R7) out of seven sampled residents that had the potential for abuse/neglect of care was immediately reported to the State Agency, thoroughly investigated and reported the results of the investigations within 5 working days to the DLTCRP (Division of Long Term Care Residents Protection). Findings include: Review of R7's MDS (Minimum Data Set) revealed that resident is alert and oriented times three (person, time and place). Review of nurses notes dated 12/12/11 at 6:15 AM revealed that E9 (C.N.A) called E10 (LPN) to R7's room where it was observed that there was a large amount of dried blood on his sock over the right great toe. This was confirmed with E9 (CNA) on 12/19/11 and E10 (CNA) on 12/10/11. The next nurse's note written on 12/12/11 at 2:00PM revealed that R7's right great toe was cleansed with normal saline and a clean dry dressing applied. The old dressing was saturated with bloody discharge. The area was assessed to have (2) small open areas on the left outer aspect of the right great toe. In an interview with E10 (LPN) on 12/20/11, he stated that the morning of 12/12/11 he was told in report that R7 was seen by the Podiatrist a day or so before and that the Podiatrist had cut/injured	F 225	483.13(c)(1)(ii)-(iii), (c)(2)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (con't) 3 All staff will be inserviced regarding Abuse, Neglect, and Mistreatment and Incident Report process to be completed by 1/30/12. 4 Incident Reports will be reviewed for compliance with Delaware Administrative Code Title 16, 3000, 3201 weekly X 4, then monthly X 2 and reported through QA process.	1/30/12 1/30/12

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F 225	Continued From page 7 R7's toe. When E10 assessed the toe on the morning of 12/12/11, it already had a blood soaked bandage on it. Review of physician's orders dated 12/12/11 at 2:30 PM, revealed an order to cleanse right great toe with normal saline, apply bacitracin and Band-Aid everyday until healed. In an interview with E11(Unit Manager) on 12/16/11 in which she stated that the podiatrist injured R7's toe on her last visit. E11 stated that she reported this to E2 (DON) but did not do an incident report. E3 (ADON) confirmed an incident report was not completed. Review of R7's medical record revealed that there was no podiatrist's notes for this visit and no documentation by the nursing staff or the podiatrist of any injury to R7. In an interview with R7's brother, who is the contact person, revealed that he was told by the facility on 12/13/11, when R7 returned from the hospital, that the C1 (Podiatrist) cut/injured his brother's toe. In an interview on 12/19/11 with C1(Contracted Podiatrist) she stated that she saw R7 at the facility on 12/9/11 and that she only trimmed three toenails on each foot. She assessed R7's two great toes and did not see cuts or injuries of any kind at this visit. C1 (Podiatrist) also stated that she did not inflict any injury to this resident at this time and if she had she would have reported it to the facility and treated it. In an interview with R7 on 12/19/11, he stated	F 225	See Previous Page	

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F 225	Continued From page 8 that the C1 (Podiatrist) did not cut/injure his toe on 12/9/11, and that on 12/11/11, E8 hit his toe on the dresser while she was transferring him from his wheelchair to his bed. The facility's documented incident report dated 12/16/11 indicated that the incident occurred on 12/8/11 which also indicated it was a known source and did not reflect the accurate incident. However, upon further investigation after being brought to the attention of the staff by the surveyor, it was revealed that R7's injury to his right great toe was not caused by the podiatrist, but by E8 (CNA) who transferred resident from his wheelchair to his bed by herself and hit his toe on the dresser. The facility failed to write an incident report regarding an event that had the potential for abuse and/or neglect of care by a CNA and failed to thoroughly investigate and report results of the investigation within 5 working days of the incident to the DLTCRP.	F 225	See Previous Page 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 1. R7 is alert and oriented X 3 and is able to express himself. R7 was distressed by the surveyors' allegation and categorically denies feeling abused, neglected, mistreated, or lacking in dignity or respect for his individuality as communicated by the resident during the facility's investigation. The CNA's comment was in reference to the temperature of the wipes being used at the time. An investigation and incident report was submitted to the DLTCRP.	12/16/11
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based upon observation it was determined that the facility failed to promote care for one (R7) out of seven sampled residents in a manner and in an environment that maintains or	F 241		

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F 241	Continued From page 9 enhances each resident's dignity and respect in full recognition of his individuality. Findings include: 1. Observation on 12/16/11 at 1:40 PM of R7 during incontinence care revealed that R7 had a reddened fungal rash to his abdomen, groin, genitals and inner thighs. While R7 was standing up to the grab rail next to the toilet, E12 (C.N.A.) was holding R7's right arm while E13 (C.N.A) was cleaning resident's groin area with wipes. E13 made this statement to R7, " Do you want me to heat em up, put them on fire. It's not my fault. " Review of R7's MDS (Minimum Data Set) dated 11/3/11 revealed that R7 is alert and oriented x3 with a BIMS (Brief Interview for Mental status) score of 15. Findings were confirmed with E11 and E14 (Social Services Director) on 12/16/11.	F 241	2. Any resident could potentially be affected. 3. All staff will be inserviced regarding Abuse, Neglect, and Mistreatment and Incident Report Process to be completed by 1/30/12. 4. Random Peri Care audits will be conducted by the Staff Developer/designee weekly X4, then monthly X 2 to ensure dignity and respect of individuality is present and will be reported through the QA process.	1/30/12 1/30/12
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 1. R5 no longer resides at the facility. She expired on 9/10/10. The diagnosis of "Ischemic Vasculopathy" was not noted as a diagnosis on 5/27/10, as it did not exist as a diagnosis to the facility's knowledge until 12/16/2011 (more than 15 months after R5 left the facility). The Medical Director wrote this in his letter	

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F 280	Continued From page 10 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the care plan was reviewed and revised for 1 (Residents # 5) out of 7 sampled residents. Findings include: Cross refer F309 Review of R5's medical record revealed she was admitted from home on 3/22/10 with diagnoses of ASCVD (arteriosclerotic cerebral vascular disease), Dementia, Diabetes Type 11, hypercholesterolemia and a history of constipation. Review of R5's Care Plan initiated on 3/22/10 entitled "Potential for Constipation" with the goal "Resident will have a BM at least Q(every) 3 days x 92 days". The interventions/approaches were as follows: 1.Monitor BM's and document. 2. Meds as ordered; 3. Consult Dietitian PRN; 4. Encourage fluids as per diet allows; 5. Follow Facility Protocol. The initiated care plan dated 3/22/10 was not revised on 5/27/10 after her re-admission to the facility and failed to be individualized to reflect	F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP (con't) of explanation to the surveyor during the survey. Therefore, no possibility to update the careplan existed. R5's BM's were monitored and documented, weights were monitored weekly and results communicated to the IDT and M.D. 1/30/12 2. Any resident may be affected under F280 1/30/12 3. The facility interdisciplinary team (IDT) will review readmissions and discuss and implement plans of care as appropriate. 1/30/12 4. The RNAC/designee will review selected care plans during the facility weekly "High Risk" meeting, quarterly and annually and at times of significant change and report through the QA process. 1/30/12	

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F 280	Continued From page 11 and/or identify R5's clinical cause of constipation/ hospital and diagnosis of "Ischemic Vasculopathy". For example to monitor/ focus on signs and symptoms of irregular bowel movements or monitoring of her hemorrhoid and other symptoms such as diarrhea, unintended weight loss, nausea and vomiting, bloating and/or abdominal distention that may require enemas, laxatives and other chemical or physical techniques or treatments to maintain a regular bowel discipline.	F 280	See Previous Page	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that services provided on medication administration for one (1) resident (SSR8) that met professional standards of quality. Findings include: The facility's Policies and Procedures on Medication Administration stated, " Medications are administered at the time they are prepared...The person who prepares the dose for administration is the person who administers the dose...The resident is always observed after administration to ensure that the dose was completely ingested..." During tour/rounds in the F wing unit on 12/14/11 at approximately 9:30 AM, surveyor entered resident ' s room (SSR8) . Surveyor was in the	F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS 1. SSR8 suffered no untoward affect from the issue cited. 1/30/12 2. All residents have the potential to be affected by the deficient practice. 1/30/12 3. All licensed staff will be re-inserviced regarding proper medication administration by 1/30/12. 4. Random medication pass audits will be conducted by the Staff Developer/designee weekly X4, then monthly X 2 to ensure appropriate medication pass procedure is followed and will be reported through the QA process. 1/30/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. BUILDING _____ B. WING _____	C 12/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 281	Continued From page 12 room for approximately 5 minutes talking with the resident when it was observed that SSR8 ' s medication pills contained in the medicine cup was sitting on top of her small table. The medication nurse E10 (LPN) was out of SSR8's room which was 2 doors away, by the medication cart. SSR8 stated that she had the nurse leave the medication and wanted to take them later. The incident was discussed with E 10 first on 12/14/1. E3 (ADON) and E2 (DON) confirmed this finding on 12/21/11. The facility failed to ensure medications were taken according to facility policy.	F 281	See Previous Page	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one (1) resident (R5) out of seven (7) sampled residents. The facility failed to assess R5 thoroughly and failed to implement individualized interventions in	F 309	F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 1. R5 no longer resides at the facility. She expired on 9/10/10. The facility bowel protocol requires initiation of the bowel protocol after 3 days without a BM.R5 did not meet the requirement for the Bowel Protocol as she had BM's on 8/28/10 and again on 9/1/10. R5 never exceeded 3 days without a BM, as is documented by the facility and Compassionate Care Hospice. (Cross Reference F 514 page 34 of this 2567 paragraph 2), "Review of Hospice nursing notes dated 9/3/10 indicated R5 had a bowel movement on 9/1/10". Vital signs, abdominal assessments and BM's were monitored and documented, weights were monitored weekly and results communicated to the IDT and M.D. These documents were provided to the surveyors.	1/30/12

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F 309	Continued From page 13 reference to her bowel protocol and based on the knowledge of her past history. Review of the MAR for the time period of 8/29/10 through 9/2/10, the five days in which R5 was documented to have no bowel movements, revealed that the nursing staff failed to initiate/follow the Bowel Regime as indicated after 3 days of no bowel movements and/or 5 days without bowel movements. Findings include: Review of R5's medical record revealed she was admitted from home on 3/22/10 with diagnoses of ASCVD (arteriosclerotic cerebral vascular disease), Dementia, Diabetes Type 11, hypercholesterolemia and a history of constipation. Review of R5's Care Plan initiated on 3/22/10 entitled "Potential for Constipation" with the goal "Resident will have a BM at least Q(every) 3 days x 92 days". The interventions/approaches were as follows: 1.Monitor BM's and document. 2. Meds as ordered; 3. Consult Dietitian PRN; 4. Encourage fluids as per diet allows; 5. Follow Facility Protocol. While in the facility, R5 was sent to the hospital ER on 5/18/10 due to abdominal distention, loose stool x 4 days and increased weakness. At "11:15" on 5/18/10 R5 doubled over with abdominal pains-(R) lower quadrant "shooting" to rectum. Pain in rectum "10 out of 10" (pain scale), "(-) rebound tenderness to abdomen", "emesis (vomiting) x2 past 30 minutes". R5 was evaluated and treated at the hospital ER with diagnosis of constipation. A facility nurse's note written on top of the hospital's "Emergency Instructions" dated 5/18/11 stated, "Resident has been having	F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING (CON'T) 2. All residents have the potential to be affected. 3. The facility bowel protocol policy has been reviewed and a BM tracking tool will be added to the current procedure, to facilitate ease of tracking. Staff will be inserviced regarding the BM tracking tool by 1/30/12. 4. The Unit Manager/Supervisor will review the BM tracking tool daily and report results through the QA process.	1/30/12 1/30/12 1/30/12

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F 309	Continued From page 14 medium-large BM'S every day all month. Called (name of hospital) to ask how they came up with this dx (diagnosis). They said it was because she appeared to have "some external hemorrhoids which are usually caused by constipation". R5 was discharged back to the facility on 5/27/10 and was prescribed "Anusol HC 2.5 % cream bid, prn to hemorrhoids" According to R5's Significant Change in Status Minimum Data Set (MDS) assessment dated 07/05/2010, R5's cognitive skills for daily decision-making were moderately impaired-decisions poor; cues/supervision required. R5 needed extensive assistance with personal hygiene and bathing, limited assistance in bed mobility, dressing, toilet use, independent with transfer to/from bed, chair, wheelchair and standing position and ambulation in the room. R5 was frequently incontinent of bowel (coded 3) and incontinent of bladder (multiple daily episodes). She had no swallowing and chewing problem. R5 had a weight loss problem and leaves 25% of meals. A 12/16/11 statement written by C17 (attending Physician/Medical Director) for the surveyor describes R5's condition which stated, "..(.R5), among other diagnoses, suffered from Type 11 DM, cerebral vasculopathy with dementia, atherosclerosis and as part of that ischemic bowel syndrome (loss of blood flow to the intestine and can cause intestinal tissues to die, perforate and severe infection) was most probably one of her comorbidities. In fact it is consistent with irregular bowels, abdominal pains, discomfort and bouts of constipation as well as loose stools at times...Furthermore her	F 309	See Previous Page	

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F 309	Continued From page 15 history of Vasculopathy is consistent with symptoms and signs of irregular BM's that require enemas, laxatives and other chemical or physical techniques to keep a regular bowel discipline...her symptoms seem to fit the pattern ileus, itself a comorbidity of ischemic vasculopathy and, again in a larger picture, general clinical decline". If the facility and C17 (MD) were knowledgeable of this condition, it is unclear why R5's care plan was not revised. "Symptoms of chronic intestinal ischemia can include; abdominal cramps or fullness, abdominal pain, fear of eating, unintended weight loss, diarrhea, nausea and vomiting and bloating" (www/Mayo Clinic.com/health/intestinal ischemia/D500459). "Symptoms of fecal impaction are similar to those of constipation, but are complicated when the impacted stool presses on other tissues. Solid stool and other materials can back up in the colon, while liquid stools moving past the impaction can cause diarrhea or uncontrolled leakage of stool". Common symptoms of fecal impaction include abdominal pain or cramping, back pain, change in bowel habits, diarrhea, small or thin, semi-formed stools. Serious symptoms that might indicate a life-threatening condition includes, "greatly reduced or no urine output, severe abdominal pain, severe vomiting, inability to pass stool or gas." (http://www.bettermedicine.com/article/fecal-impaction/symptoms). The initiated care plan dated 3/22/10 was not revised on 5/27/10 after her re-admission to the facility and failed to be individualized to reflect	F 309	See Previous Page	

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F 309	Continued From page 16	F 309	See Previous Page	

and/or identify R5's clinical cause of constipation/ hospital and diagnosis of "Ischemic Vasculopathy". For example to monitor/ focus on signs and symptoms of irregular bowel movements or monitoring of her hemorrhoid and other symptoms such as diarrhea, unintended weight loss, nausea and vomiting, bloating and/or abdominal distention that may require enemas, laxatives and other chemical or physical techniques or treatments to maintain a regular bowel discipline.

R5's "Nutritional Assessment" dated 5/28/10 stated, "...Resident continues to have episodes of loose stools/diarrhea. At this time will add lactose-free to current diet to see if resident has lactose intolerance". R5 was on regular NCS (no concentrated sweets) therapeutic diet. A Nutritional Progress Note dated 6/1/10 stated, "...this writer was notified on this day that resident is still experiencing some loose-stools, however decreasing in frequency. Will continue with lactose free diet and will add Resource Breeze (Fruit-Flavored, Clear-Liquid Nutritional Beverage) at this time to increase PO intake" Nutrition note dated 6/10/11 indicated that R5 weighed 132.5 from an admission weight of 141.4 that reflected a decline of 8.3 lbs in 3 months (4/12/10) and 5 lbs (3.6%) in one month. R5's appetite was poor. R5's weight continued to decline from 134.9 lbs in 6/3/11 to 128.6 on 8/4/10.

R5 was first diagnosed with Lactose intolerance after the 5/28/10 nutritional assessment for episodes of loose stools/diarrhea.

According to R5's MAR (Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 17 Administration Record), this resident was receiving "Senokot (stool softener) " for constipation twice a day PO (by mouth) since 6/3/10. Review of R5's July/2010 C.N.A. BM (bowel movements) flow sheets revealed that she was having regular bowel movements (BM) (small, medium, large) at least two to three times per day. Review of R5's BM flow sheets for August 2010 revealed that from 8/1-8/20/10, R5 was only having medium sized BM's regularly once a day on the 7-3 PM shift instead of two to three times a day. Then from 8/21/10-8/28/10 her BM's were irregular (0-small, medium and large once or twice a day). R5 had 0 Bowel movements for 5 days from 8/29-9/2 (5) and followed by irregular bowel movements from 9/3/10 to 9/10/10 per CNAs ADL flow sheets. The type or consistency of the stool was not identified. Review of facility policy dated 2/10 entitled "Bowel Regime" (to avoid constipation and fecal impaction) stated, " Resident bowel movements will be documented by the C.N.As and documentation will be reviewed by the licensed nursing staff every day. " "The Unit Clerk will notify Unit Manager/Charge Nurse if resident has not had a bowel movement in (3) three days. The Unit Manager/ Charge Nurse will ensure Bowel Regime is initiated. Interviews on 12/16/11 with E16 (Nurse) and E17 (RN Unit Manager) revealed that the unit clerk comprises the BM list on a daily basis in the morning for review by the nurse.The facility's Bowel Regime/Protocol was as follows: * 7-3 nurse will give Prune Juice by morning medication pass, if no results this shift; * 3-11 nurse will give MOM (Milk of Magnesia) 30ml (Milliliters) (Standing Order policy) by	F 309	See Previous Page	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 18 evening medication pass, if no results this shift; * 11-7 nurse will give Fleets Enema (Standing Order policy) by first medication pass, if no results on 11-7 shift; * 7-3 nurse will notify physician. All nurses must document appropriate intervention on MAR (Medication Administration Record), Bowel Regime Intervention Form and 24 hour report. Resident will remain on the 24-hour report until resolved. Additionally, "Anusol HC 2.5 % cream bid, prn to hemorrhoids" was not documented as being administered for the months of August 2010 and September 2010. An additional diagnoses of diarrhea and failure to thrive was added by the physician on 9/2/10 POS (Physician's Order Sheet). A nurse's note dated 9/8/10 stated that "Resident complained (c/o) back pain and was medicated with Tylenol 650 mg po (by mouth), refused dinner. On 9/9/10 R5 was given 1/2 pint of milk for lunch, magic cup (contains skim milk, non-fat dry milk and not lactose free per Hormelhealthlabs.com/product) and ice cream. On 9/10/10 at 0100 (1:00 AM) R5 complained of pain and discomfort, vomit x1 moderate amount of brownish liquid with odor of feces. Upper and lower extremities mottling, bowel sound diminishing, vomiting and low pulse ox and she was sent to hospital ER for evaluation. According to the hospital's Discharge Summary dated 9/10/10, R5 presented to the hospital in severe septic shock with a distended abdomen. A CAT scan of the abdomen showed a severely	F 309	See Previous Page	

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F 309	Continued From page 19 dilated left colon with free air in the abdominal cavity. R5 underwent an exploratory laparotomy and was found to have extensive contamination of the abdominal cavity. She underwent an extended left hemicolectomy and found to have an ischemic-appearing small bowel as well as stomach. R5 expired at 1822 (6:22 PM) on 09/10/2010. Discharge Diagnoses: Severe septic shock and Perforated colon status post extended left colectomy. The facility failed thoroughly assess R5 and failed to follow the facility policy for bowel regimen. Although the facility identified R5's clinical cause of constipation per hospital evaluation including the diagnosis of "Ischemic Vasculopathy", the facility failed to individualize the plan of care to maintain a regular bowel regimen for this resident.	F 309	See Previous Page	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on closed clinical record review and interview, it was determined that the facility failed to ensure that one (1) resident (R1) out of 7	F 314	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 1. R1 expired 12/06/11. R1's single small blister noted to left heel was caused by R1's shoe as documented by the physician (Dermatologist/Plastic Surgeon). R1 was wearing shoes so as to safely ambulate and participate in rehab. There is no evidence whatsoever that R1 ever had a Stage 4 wound on his sacrum as evidenced by facility and hospital records.R1 was placed on a low	

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F 314	Continued From page 20 sampled, who entered the facility without pressure sores did not develop pressure sores unless the individual ' s clinical condition demonstrates that they were unavoidable. According to R1 ' s admission Minimum Data Set (MDS) assessment dated 10/5/11, R1 had no pressure ulcer but was at risk for developing pressure ulcers. However, on 10/15/11, R1 was found with a blister on his left heel and was assessed by the wound care nurse on 10/17/2011 as Stage 2 left heel pressure ulcer measuring 5.0x4.0 cm. with macerated surrounding skin. The wound was treated with Collagen (highly absorbent material converts to soft, gel sheet that stays in intimate contact with wound bed as it absorbs exudate). On 11/8/11 this left heel pressure ulcer was assessed again by the wound care nurse as unstageable with serous-sanguinous drainage, macerated surrounding skin and 50% necrotic and treated with Santyl (ointment, an active enzymatic therapy that continuously removes necrotic tissue). On 11/14/11, R1 was sent to the hospital for signs and symptoms of dilated, non-reactive to light of the right pupil after an incident of fall and returned to the facility after 7 hrs. While in the hospital, R1's body was assessed by a Forensic Examiner and found with a previously undocumented Stage 4 pressure ulcer on the buttocks. Per Weekly Wound Assessment documentation, on 11/21/11 the wound care nurse had observed and evaluated R1's right heel and found a stage 2 pressure area (pink) measuring L2.0xW.5xD2. Findings include: R1 was admitted to the facility on 9/28/11 from the hospital with diagnoses that included CAD (coronary arterial disease) HTN (hypertension),	F 314	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (CON'T) air loss, alternating pressure mattress (a pressure *relieving* mattress) on 11/7/11. On 11/23/11 R1 developed an unavoidable stage II wound on his right ankle a full 38 days after the area described on his left heel was observed, despite the intervention of the low air loss alternating pressure mattress, off-loading of heels and because of his significant co-morbidities. 1/30/12 2. All residents have the potential to be affected. 1/30/12 3. Staff will be re-inserviced regarding compliance with documentation on TAR/CNA flow sheets by 1/30/12. 1/30/12 4. Unit Manager/designee will review TAR/CNA record for compliance with documentation for those residents with heel protectors weekly x 4, then monthly x 2 and report through QA process. 1/30/12	

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F 314	Continued From page 21 dysthymic disorder (depression) hyperlipidemia (high cholesterol), history of CABG (coronary arterial bypass surgery), AFIB (arterial fibrillation), BPH (benign prostatic surgery) and hearing loss (deaf) (communicated using a writing board). According to the facility ' s admission " Skin Integrity Action Sheet " assessment dated 9/28/11, R1 had hematoma (contusion) from his left upper buttock down to his mid leg, bruises on his left arm and skin tear on his right buttock as a result of a fall at home. R1 was assessed as a low risk (scored 19 on Braden scale) for pressure sore. R1 ' s admission Minimum Data Set (MDS) assessment dated 10/5/11 indicated that his BIMS (Brief Interview for Mental Status) score was 07 out of 15. He had no behavior problem. He was independent non-ambulatory, needed extensive assistance from staff with bed mobility, (moves to and from lying position, turn side to side, position body while in bed), transfer (to or from bed, chair, wheelchair, standing position), dressing and toilet use. R1 was totally dependent upon staff for his personal hygiene. R1 had no pressure ulcer but was at low risk for developing pressure ulcers. The facility initiated a care plan dated 9/28/11 on " Potential for alteration in skin integrity", " Adm. (admitted) with skin tear, buttocks", " Refusing to turn and wants to be in bed all the time except for therapy (Physical and Occupational Therapy) " . The care plan goal was: Resident ' s skin will not show signs of breakdown x 92 days The 9/28/11 care plan interventions/approaches	F 314	See Previous Page	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 22 included : Nurse will assess resident ' s skin on admission, readmission, every week, and as needed Staff to assist resident to the extent required with turning and positioning every 2 hours and prn (as needed) Staff to check skin every 2 hrs and report changes to nurse/DR. Pressure reduction mattress Heel protectors while in bed (heels have relatively little surface area, it is difficult to redistribute pressure on this surface) Keep skin clean and dry Keep bed linens wrinkle free Encourage mobility Monitor and assist with food and fluid intake Consult dietician as needed In an interview with E15 (RN, Staff Development) on 12/20/11 at about 8:35 AM confirmed that the CNAs' were taught to check skin for pressure areas, reddened areas and/or anything abnormal during daily care of residents (i.e.washing, showering, turning and repositioning) . Skin assessments are done from head to toe by Nurse and CNAs. Another care plan was initiated on 9/28/11 on "Potential for injury related to S/P fall prior to admission from home with interventions that included "Encourage appropriate footwear with ambulation and one (1) person assist with roller walker (RW)" Review of R1 ' s CNAS ' October/2011 ADL (activities of daily living) Care flow sheet included the ADL care to " Turn and Reposition and Skin Assessment every 2 hrs and report any skin	F 314	See Previous Page	

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	085004	A. BUILDING _____ B. WING _____	C 12/21/2011

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F 314	Continued From page 23 change to Nurse " Each daily block of the 10/2011 and 11/2011 flow sheet were signed off as completed by the CNAS in all 3 shifts (the every 2 hours skin assessments and turning and repositioning). However, the "heel protectors while in bed" as per care plan were not addressed in the CNA's ADL flow sheet as part of the care. In addition, the weekly skin assessment blocks in the 10/2011 and 11/2011 TAR (Treatment Administration Record) were initialed by the licensed nurses as completed each week from 10/5/11 through 11/30/11. As per facility's "Weekly Skin Assessment" policy. "If there is no problem with skin integrity, document on the Weekly Full Body Assessment form in the designated space for description, location and evaluation". There were no "Weekly Full Body Assessment" forms found for 10/5/11, 10/12/11. 10/19/11 and 10/26/11 and or documented results of nursing skin assessments/comments at the designated space at the back of R1's TAR and/or nurses' notes. A nurse's note dated 10/8/11 stated, "...Res. (Resident) c/o (complained of) #6/10 (pain scale of 6 out of 10) throbbing pain to (R) leg/heel. Heels off-loaded, repositioned Res. and applied lotion to BLE (bilateral lower extremity). Medicated Res. with PRN Vicodin 5/500 mg. po (by mouth) and on F/U (follow up) Res. stated "Pain down to #2/10 and I need something to take away this pain". A nurse's note dated 10/15/11 timed 1240 stated, " .... " Resident received shower today ...He has a blister on (L) heel informed treatment nurse	F 314	See Previous Page	

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F 314	Continued From page 24 (name)". Per "Weekly Wound Assessment" form, E4 (Wound Care Nurse) documented that she first observed the left heel blister on 10/17/11 and assessed it as a Stage 2 pressure ulcer, size L5.0xW4.0 cm with serous-sanguineous drainage, pink color of the wound bed, surrounding skin macerated and treatment of choice was the Collagen. R1 intermittently complained of right foot pain, right leg, toes, ankles and foot accompanied by constant moaning and crying without tears (nurses' notes 10/15/11,10/16/11, 10/17/11, 10/26/11 and 10/27/11). Ativan and Vicodin 5/500 tab were administered twice plus "skin prep (a liquid dressing that leaves a clear, waterproof, and breathable film barrier to protect intact and damaged skin from irritation). Subsequently, review of R1's TAR revealed that on 10/17/11 the following care was prescribed/initiated: a. Off load heels, B/L (bilateral) heel protectors on at all times b. Apply skin prep to (R) heel q (every) shift c. Cleanse (L) heel with NSS (normal saline solution), apply collagen and foam dsg (dressing) QD (every day) and PRN (as needed)" Review of R1's Left Heel "Weekly Wound Assessment" record, revealed the following findings by E 4(wound care nurse): a. 10/24/11 assessment stated, "Stage 2 pressure sore, size L2.0 x W1.8, no drainage, pink wound bed, surrounding skin unremarkable,	F 314	See Previous Page	

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F 314	Continued From page 25 treatment Collagen". b. 10/31/11 assessment stated, "Stage 2 pressure sore, size L1.5 x W1.3 cm, bloody drainage, pink wound bed, treatment collagen". c.11/8/11 assessment stated "unstageable with sero-sanguinous drainage , macerated surrounding skin and 50% necrotic (dead tissue), measured L2.4x W1.6x D.2 cm. Santyl was the treatment of choice. d. 11/21/11 unstageable, 80% necrotic, unremarkable surrounding skin, color of wound bed was black/pink, worse, measured L3.0 x W2.5xD.2 cm. Santyl remained as the treatment of choice. The area of the left heel was seen by C16 (Wound Care Specialist, D.O.) on 11/21/11. According to his assessment the left heel wound size was L3xW2.5 x D 0.2 cm; surface area 7.5cm2, no exudate, 80% thick adherent devitalized necrotic tissue, 20% granulation tissue. Additional information: wound started from Trauma from shoes. (Per E2, DON written statement dated 12/22/2011, R1 was out of bed frequently for therapy (Rehabilitation) and ADL's throughout the day and was wearing his shoes appropriately). Procedures -surgical excisional debridement of subcutaneous tissue of the left heel was done on 11/21/11 by C16 (D.O.) with the family member's consent. Recommendations: off load wound, no shoes until fully healed, float heels in bed, bilateral heel protectors, protein supplementation and consult for E-Stimulation Treatments.	F 314	See Previous Page	

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F 314	Continued From page 26 Additionally, according to the "Weekly Wound Assessment" sheet, E4 (wound care nurse) documented that she first observed the Right heel wound on 11/21/11 and was assessed as a Stage 2 pressure sore. On the same day, 11/21/11, C16's (wound care specialist-D.O.) assessed this right heel wound. Per C16's evaluation this right heel wound measured L2 x W1.5 x D 0.2 cm, surface area 3.0 cm2, no exudate, granulation tissue 100%, dressings weekly with Tegaderm absorbent. On 11/28/11 E4 (wound care nurse) observed the right heel wound and assessed it as unstageable (U), size L 1.5 x W1.2 x D.2, black/pink, worse and treated it with Santyl. The wound care specialist evaluated it as follows: size L1.5 x W1.2 xD0.2 cm, surface 1.80 cm2, no exudate, 10% thick adherent devitalized necrotic tissue; 90% granulation tissue, decreased surface size and improved. Recommended dressing daily with Santyl; off-Load wound, float heels in bed, heel protectors to Off-load wounds, no shoes until fully healed. According to the Weekly Wound Assessment dated 12/5/11 of the right heel by E4 (wound care nurse) the wound was (U) unstageable, size L1.4 x W1.0 x D.2 cm, serous-sanguinous drainage, black/pink wound bed, necrotic tissue 10%, improved, treatment- santyl. "Pressure ulcers are sores that occur when pressure cuts off the blood supply to the skin. The stress that is caused by the body's weight, and the impact of the foot striking the ground can place the big toe, the heel and the ball of the foot	F 314	See Previous Page	

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F 314	Continued From page 27 at greatest risk for pressure ulcers...Red "hot" spots on the skin are signs of pressure or friction. They are warning that you need to take care of your feet. If pressure is not relieved, a hot spot is likely to blister. Left untreated, a blister can turn into an open wound..." (Foot Care Library/Foot Care Center http://www.bunionbusters.com/footcare/ulcers.asp). According to the facility's Weekly Wound Assessment guidance, "Stage 2: a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater". In addition, the facility's policy on Skin Care Protocol provided to the surveyor by the facility included an attachment entitled "JAMA Vol. 289 No.2, January 8, 2003", the facility's guide on Pressure Ulcers. It stated, "Stage 1-an observable, pressure related alteration of intact skin, whose indicators....may include changes in one or more of the following parameters" which included "Sensation (pain, itching); and/or a defined area of persistent redness may appear...." A typed written statement submitted by E2 (DON) dated 12/22/11 to the office of the DLTCRP was reviewed. According to the statement, "R1 was out of bed frequently for therapy and ADL's throughout the day and was wearing his shoes appropriately when out of bed". R1's skin was checked per facility policy and skin was noted to be intact from 9/28/11 until a small blister was noted on his Left heel on 10/17/2011. Review of R1's record revealed that the facility	F 314	See Previous Page	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 28 had a care plan in place to address R1's problem related to his "Potential for alteration in skin integrity" and put in place preventative measures such as "Nurse will assess resident's skin on admission, readmission, every week, and as needed, "Staff to assist resident to the extent required with turning and positioning every 2 hours and prn (as needed)" and "Staff to check skin every 2 hrs and report changes to nurse/DR". However, the facility failed to recognize and/or identify signs and symptoms of impending risk factors such as reddened skin and/or callous or anything abnormal during every 2 hour skin assessments, as directed in the October, 2011 CNA'S ADL Care Flow sheet prior to 10/15/11. In addition, one of the preventative measures identified in the care plan dated 9/28/11 was the use of heel protectors while in bed (off load the heels). The facility failed to demonstrate that this preventative measure was consistently implemented before 10/17/11. The supportive device of floating heels was not addressed in the TAR until 10/17/11 and CNAs ADL Care Flow sheet. The "heel floats" were included in the CNA's "Resident Care Profile" on 11/16/11 when it was updated and or TAR to ensure that this preventative device was consistently implemented. The pressure sores on the right heel and left heel were discovered as Stage 2 and eventually declined into an unstageable stage. Review of R1's "Weekly Full Body Assessment" the location on the body diagram of the left and right heel skin issues (circled) indicated the underside and back of the heels. The implementation of the heel protectors/off	F 314	See Previous Page	

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F 314	Continued From page 29 loading to bilateral heels was initiated on 10/17/11 as documented in the TAR when R1's Stage 2 right heel wound was identified/evaluated by the wound care nurse. Again, it was not included in the CNA's ADL Flow sheet even though the CNAs provided the daily care for R1 to ensure that R1 had the heel protector device and or off loaded consistently. Additionally, R1 was admitted to the facility on 9/28/11 with a skin tear on his right buttock. On 11/7/11 a note was documented on the "Wound Notes" which stated, "Received report of open area on sacrum. Upon assessment bilateral buttocks, red, non blanchable with excoriation across area...New order received-cleanse buttocks with soap and water-apply Calmoseptine (moisture barrier cream). According to the 11/2011 TAR, treatment was being applied 3 times a day (all 3 shifts). However, there was no record found of a weekly wound assessment/daily nurse's notes on the condition of this excoriated buttocks in the resident's clinical record as required by R1's care plan. On 11/14/11 at 0140 AM, R1 was sent out to the hospital after an incident of fall. According to the hospital record's "Forensic Evaluation" dated 11/14/11, R1 was assessed with an abnormal findings of "Stage 4 pressure ulcer" on the buttocks. R1 returned to the facility on 11/14/11 at 0900. No record of assessment was found related to the hospital findings on the buttocks.	F 314	See Previous Page	
F 501 SS=D	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director.	F 501	See Following Page	

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F 501	Continued From page 30 The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the medical care for one (1) resident (R1) out of 7 sampled was coordinated by the medical director and ensured the availability of the attending physician to provide consultation in case of an emergency. Findings include: A nurse's note dated 11/14/11 stated, "Resident (R1) found lying on his back on the landing strip beside his bed with head off the floor at 2335 (11:35 PM) by CNA assigned...While performing neuro check when resident in bed by Supervisor; (R) pupil is dilated and non-reactive. MD (Medical Doctor) notified by Supervisor at approximately 2400 (12:00 AM); received no call back...ADON notified approximately at 1:00 AM. Supervisor called 911 to send resident to ER for further evaluation. Resident picked up by EMT at 0135". Interview with E3 (ADON) and E2 (DON) on 12/15/11 at 3:45 PM stated that the resident's attending physician (also the facility's Medical Director) never called back. So, the Facility decided to send the resident to the hospital. The physician's telephone number was connected to an on call service which paged the physician to call back. The physician was in the facility at 5:00 AM the following morning when the nursing staff made him aware that he never called back and	F 501	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR 1. R1's physician was notified of a fall via telephone as a message was left with the answering service. R1 was sent to the hospital for evaluation by the facility in a timely manner and there was no delay in treatment or care. R1's physician (who is also the Medical Director) arrived at the facility as is his usual practice at 0500 that morning. 2. All residents have the potential to be affected. 3. The facility will review the on call policy with the Medical Director. 4. The DON/designee will review calls made to the physician to monitor call back weekly X 4, then Monthly X 2 and report through the QA process.	1/30/12 1/30/12 1/30/12 1/30/12

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F 501	Continued From page 31 that the resident was sent to the hospital. When the physician was asked who was on call that night, he never gave the name as he wasn't sure who was on call.	F 501	See Previous Page	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based upon record review it was determined that the facility failed to accurately and completely document the resident's status, the care and services provided in accordance with current professional standards and practices and provide a basis for determining and managing the resident's progress including response to treatment, change in condition, and changes in treatment for one (R5) out of seven sampled residents. Findings include: Review of R5's medical record revealed that she has a diagnosis of ASCVD (Atherosclerosis Cardio Vascular Disease), Dementia, Diabetes	F 514	483.75(1)(1) RES RECORDS-COMPLETE/ACCURATE/ ACCESSIBLE 1. R5 no longer resides at the facility. The facility bowel protocol Requires initiation of the "Bowel Protocol" after 3 days without a BM. R5 did not meet the requirement for the Bowel Protocol as she had BM's on 8/28/10 and again on 9/1/10. R5 never exceeded 3 days without a BM as is documented by the facility and Compassionate Care Hospice, as verified under this tag on page 34 paragraph 2, "Review of Hospice nursing notes dated 9/3/10 indicated R5 had a bowel movement on 9/1/10".These documents were provided to the surveyors. Vital signs, abdominal assessments and BM's were monitored and documented, weights were monitored weekly and results communicated to the IDT and M.D.	1/30/12

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F 514	Continued From page 32 Type II, Hypercholesterolemia and a history of constipation. Review of documentation dated 12/16/2011 from C1(Medical Director), revealed that R5 also has a diagnosis of ischemic bowel disease. Review of C.N.A (Certified Nursing Assistant) flow sheets for bowel movement monitoring, R5 did not have a bowel movement from 8/29/10 through 9/2/10, a total of five days. Review of facility policy dated 2/10 entitled Bowel Regime states, " Resident bowel movements will be documented by the C.N.A's and documentation will be reviewed by the licensed nursing staff every day. " The purpose of the policy states, " To avoid constipation and fecal impaction. " The procedure states, " The Unit Clerk will notify Unit Manager/Charge Nurse if resident has not had a bowel movement in (3) three days. The Unit Manager/ Charge Nurse will ensure Bowel Regime is initiated as follows: * 7-3 nurse will give Prune Juice by morning medication pass, if no results this shift; * 3-11 nurse will give MOM (Milk of Magnesia) 30ml (Milliliters) (Standing Order policy) by evening medication pass, if no results this shift; * 11-7 nurse will give Fleets Enema (Standing Order policy) by first medication pass, if no results on 11-7 shift; * 7-3 nurse will notify physician. All nurses must document appropriate intervention on MAR (Medication Administration Record), Bowel Regime Intervention Form and 24 hour report. Resident will remain on 24-hour report until resolved.	F 514	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR (CON'T) 2. All residents have the potential to be affected. 1/30/12 3. The facility policy has been reviewed and a BM tracking tool will be added to the current procedure to facilitate ease of review. Staff will be in-serviced regarding the BM tracking tool by 1/30/12. 1/30/12 4. The Unit Manager/Supervisor will review the BM tracking tool daily and report results through the QA process. 1/30/12	

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F 514	Continued From page 33 Review of MAR for the time period of 8/29/10 through 9/2/10 revealed that the Bowel Regime was not initiated for R5 per policy. Review of Hospice nursing notes dated 9/3/10 indicated R5 had a bowel movement on 9/1/10. This was not indicated on C.N.A flow sheet. In an interview on 12/19/11 with C2 (Director of Nursing for Compassionate Care Hospice) with which R5 was a client, she stated that the hospice nurse compiles her information from the documentation from the facility C.N.A flow sheets and by asking facility staff for bowel movement information. It was also stated that the Hospice staff should be reporting to facility staff when residents have bowel movements while they are there performing care. Facility failed to accurately and completely document R5's bowel movement status so that care and services could be performed according to facility Bowel Regime Policy for a resident with a diagnosis of ischemic bowel syndrome and a history of constipation.	F 514	See Previous Page	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Brandywine Nursing and Rehab Center **DATE SURVEY COMPLETED:** December 21, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced complaint visit was conducted at this facility from December 14, 2011 and concluded on December 21, 2011. The census the first day of the survey was 160. The sample size included 1 active and 6 closed records. Additionally, there was one (1) active subsampled resident. The deficiencies in this report are based on record review, interviews, observations, and other documentation review as indicated.	
3201	**The Skilled and Intermediate Care Nursing Facilities**	
3201.10	**Scope**	
	Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.	
	Cross refer to the CMS 2567-L survey report date completed 12/21/11 F162, F225. F241, F280, F281, F309, F314, F501, F514.	For plan of correction, please cross refer to the CMS 2567-L survey report date completed 12/21/11 F162, F225, F241, F280, F281, F309, F314, F501, F514 Date of Correction: 1/30/12

Provider's Signature Fred Wisniewski Title Administrator Date 1/20/12